pediatric dentistry
BIRMINGHAM, AL

721 Montclair Road
Birmingham, AL 35213
205-879-6150

Dr. Clark Thomas Pediatric Dentistry

Office Policies

Thank you for choosing our office to provide your child with quality dental care. We strive to provide all our patients with a pleasant, happy and fun visit. In order for us to provide a high standard of care we must follow the following office policies. Please read over our policies and initial each one and sign at the bottom showing that you have read and understand our policies

Broken Appointments– 24 hour notice is required to cancel or change your child's dental appointment. Three (3) broken appointments within a twelve (12) month period will result in the dismissal of your child from our practice.

(Exceptions to this policy will be determined on an individual basis, according to circumstance. We understand that occasionally, children's illness or other unexpected emergencies arise that make it necessary to cancel an appointment with less than 24 hour's notice. Please be courteous and contact our office as soon as possible, so that we can offer that appointment to another child waiting for an appointment.)

Initial: ________________

Late Arrivals – If you arrive more than ten (10) minutes late for your scheduled appointment time you may be asked to reschedule. Depending on our daily schedule you may be able to be worked in. If you agree to do so you must wait until an appointment time is available or another patient reschedules. **Please note: the 11:30 a.m. and 4:30 p.m. appointments will have to be rescheduled**

Initial: ________________

***Courtesy Confirmation* –** Our office provides a call and/or e-mail confirmation approximately two working days before your scheduled appointment. Please remember this is a courtesy, and you are still responsible for keeping your scheduled appointment time. Please respond to this confirmation so we can plan accordingly to meet your child's needs.

Initial: ________________

***Dental Insurance* –** Please provide our office with your current insurance information before arriving for your child's dental appointment so that we may provide you with the estimated cost of your appointment.

We file your dental insurance as a courtesy to you. **Initial:** ____________

We do not have a contract with your insurance company, only you do. **Initial:** __________

Most insurance companies only pay a portion of the dental fees, which means you are responsible for your deductible and the **estimated** portion at the time of service. Because insurance policies vary greatly we can only **estimate** coverage in good faith. **We at no time guarantee what your insurance will and will not cover.** **Initial:** _____________

It is your responsibility to determine if you are required to see a preferred provider. Please understand that if you choose to see a non-preferred provider that your insurance may or may not pay the full amount or any at all. **Initial:** _____________

After sixty (60) days if your insurance has not rendered payment you are responsible for the entire balance paid in full. If insurance should pay after the balance has been paid we will be happy to issue you a refund check. **Initial:** _____________

It is the patient/parents responsibility to notify our office of any change with your dental insurance carrier. **Initial:** _____________

***Returned Check Fee* -** There is a $30.00 returned check fee on all returned checks.

Initial: ________________

Private Pay- Payment is due in full at the time of service. **Initial:** ________________

Child's Name: _________________________

Signature:_____________________________ **Date:**______________

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MEDICAL HISTORY

Patient Name ______________________________ Date of Birth _______________ Male/Female _____

Do you (patient) have any disease, condition, or problem that you think this office should know about that is not listed below? If yes, please name and describe ____

Does your child need to be pre-medicated? ________ What condition? ______________________________

PLEASE CHECK ALL CONDITIONS THAT APPLY:

- ☐ **NO MEDICAL CONDITIONS**
- ☐ Abnormal Bleeding
- ☐ ADD or ADHD
- ☐ Allergies (food or environmental)
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Autism
- ☐ Bleeding Problems
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Cancer – Chemotherapy
- ☐ Cerebral Palsy
- ☐ Congenital Heart Defect
- ☐ Cosmetic Surgery
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Down Syndrome
- ☐ Drug Abuse
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fever Blisters
- ☐ Frequent Headaches
- ☐ Genetic Disorders
- ☐ Glaucoma
- ☐ HIV and AIDS
- ☐ Hay Fever
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sickle Cell Disease/Trait
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Yellow Jaundice
- ☐ OTHER ________________

List any medications you (patient) are currently taking:

____

Please Check Any Known Allergies: ____

☐ **NO KNOWN ALLERGIES**

☐ Codeine

☐ Erythromycin

☐ Latex

☐ Penicillin

☐ Tetracycline

☐ Aspirin

☐ Dental Anesthetics

☐ Jewelry

☐ Metals

☐ OTHER ______________________________

Do you (patient) smoke or use tobacco?

☐ Yes ☐ No

If the patient is female, please answer the following:

Are you taking Birth Control Pills?

☐ Yes ☐ No

Are you pregnant? If Yes, # of weeks ________

☐ Yes ☐ No

Are you nursing?

☐ Yes ☐ No

Signature: ______________________________ Date: ______________________

(If under 18, Parent or Guardian Signature Required)

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Our dental office sends appointment reminders, information about treatment, payment and insurance and other communications. Please tell us how you would like us to communicate with you.

List all patients this information applies to (please print):

____

____

____

By checking the box, I consent to the following: The dental practice or its service provider may contact me to provide healthcare information such as appointment reminders and information about my treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing.

Check and complete *all that apply* (please print clearly):

☐ Contact me by mail at the following address:

____

☐ Contact me by e-mail at the following address:

____

☐ Call me at the following numbers: 1.

2.

3.

☐ Text me at the following number(s): ______________________

Signature: ______________________ Date: ______________

Please note that it is the parent(s) or legal guardian(s) responsibility to notify our office immediately if there is any change in the information provided, or if they want to stop any or all forms of communication .

Ex: new phone number(s), e-mail...

For Office Use Only:

Consent revoked. Date/ Initials: __________/ __________

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PATIENT INFORMATION

Please take a moment to enter or update your information to help us ensure that the quality of your care is excellent.

Name ______________________ Goes By ______________ Date of Birth ____________

Whom may we thank for referring you to our practice? ______________________________

PARENT/GUARDIAN INFORMATION

Name ______________________ Date of Birth ____________ SSN ______________

Home Phone ______________ Work Phone ______________ Cell Phone ____________

Home Address ______________________ City ____________ State _____ Zip ________

Email Address ______________________________

INSURED PARTY

Insured Party Name ___________________ Date of Birth ____________ SSN ______________

Home Phone ______________ Work Phone ______________ Cell Phone ____________

Home Address ______________________ City ____________ State _____ Zip ________

Employer ______________________________

Insurance Company Name ________________ Contract # ______________ Group # ______

☐ I acknowledge that I have read the Notice of Privacy Practices (Posted on clipboard) in accordance with T Health Insurance Portability & Accountability Act of 1996 (HIPPA), and have been offered a copy of it.

Please list any person(s) in which we may discuss your children's account:

1) ______________________

2) ______________________